Ted Strickland
Governor

Helen E. Jones-Kelley
Director

30 East Broad Street Columbus, Ohio 43215-3414
jfs.ohio.gov

Feb. 19, 2008

The Honorable Henry A. Waxman
Congress of the United States
House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Representative Waxman:

Ohio's Medicaid program is pleased to submit the following document in response to your January 16, 2008 request for an impact analysis of CMS changes.

Sincerely,

John R. Corlett
Medicaid Director

attachment

Ohio – Cost Limits (Institutional Providers)

Attached is the estimated fiscal impact if the Federal Regulations related to cost limits for public providers (CMS 2258-FC) were implemented. We used CY2006 Medicaid Cost Reports and CY2006 gross payments as updated through 10/30/2007. We calculated the fiscal impact on providers that identified themselves as "non-federal government" on their CY2006 Medicaid Cost Report. Attached is an Excel Spreadsheet that summarizes the analysis. We also have a 395 page document that contains the detail to the summary sheet available upon request.

There were 972 NFs with CY2006 Medicaid Cost Reports with 25 government providers. Of these 25 providers, only one NF received CY2006 gross payments that exceeded their CY2006 Medicaid expense. Payments exceeded estimated Medicaid costs by $113,189 (all funds).

There were 419 ICFs-MR with CY2006 Medicaid Cost Reports with 66 ICFs-MR government providers. Of these 66 providers, 10 ICFs-MR received CY2006 gross payments that exceeded their CY2006 Medicaid expense. Payments exceeded estimated Medicaid costs by $2,215,625 (all funds).

This analysis estimated over a 5 year period government show that NFs would have estimated gross over payments at $600,936 (all funds) applying a 3% inflationary increase each year. Government ICFs-MR would have gross over payments at $11,763,054 (all funds) with a 3% inflationary increase each year. Total fiscal impact to implement the cost limits over a 5 year period is estimated at $12.3 million (all funds).

The assumptions are outlined in the attached document. However, to estimate Medicaid costs we took the allowable costs divided by inpatient days and multiplied by MMIS days.

CMS 2258-FC Cost Limits for Public Providers

Estimated Fiscal Impact

Nursing Facilities

Calendar Year	Estimated Government Providers	Estimated Payments	Estimated Payments Exceeding Medicaid Costs: Number of Providers	Gross Overpayments	3% Increase Five Yr Estimate
CY06	25	$84,855,280	1	$113,189	$600,936

Intermediate Care Facilities for the Mentally Retarded

Calendar Year	Estimated Government Providers	Estimated Payments	Estimated Payments Exceeding Medicaid Costs: Number of Providers	Gross Overpayments	3% Increase Five Yr Estimate
CY06	66	$90,645,070	10	$2,215,625	$11,763,054

$2.3 $12.3 × 60% = $1.4 / $7.4

Assumptions:

BLTCF not using the CMS cost protocols to calculate the overpayments because :
Protocols require States to use Medicaid costs reported on Medicare Cost Reports.
BLTCF does not have Medicare Reports for either provider. ICFs-MR do not complete a Medicare report.
Medicare type cost reports have not been developed to date.
Protocols require States to blend their Medicare Cost Reports to calculate SFY08 expenses.

Cost limits apply to "unit of government" providers as determined by CMS's draft form.
BLTCF used providers that identified themselves as "non-federal government" on their Medicaid Cost Report.
BLTCF used costs reported in the CY2006 Medicaid Cost Reports for facilities identified as non-federal government.
Medicare-like Cost Reports are not available or developed for ICFs-MR.
estimated cost to facility is $1500 per facility or $99,000 per year in addition to their Medicaid Cost Report.

participation in the Ohio access success project I. ~~The~~

(G)(1) If the director establishes the Ohio access success project I, the director ~~may~~ shall adopt rules under Chapter 119. of the Revised Code for the administration and operation of the program including rules that establish all of the following:

(a) For the purpose of division (C) of this section, the application process for the project;

(b) Consistent with divisions (D) and (E) of this section, the amount, duration, and scope of benefits provided under the project.

(2) The rules the director adopts under this division may differ for the different benefits provided under the project.

(3) The director may, in accordance with Chapter 119. of the Revised Code, amend and rescind the rules adopted under this division as the director determines necessary for the administration and operation of the project.

Sec. 5111.971. (A) As used in this section, "institution" means any of the following:

(1) A nursing facility as defined in section 5111.20 of the Revised Code.

(2) An intermediate care facility for the mentally retarded as defined in section 5111.20 of the Revised Code.

(3) A hospital that is classified as a psychiatric hospital pursuant to rules adopted under section 3701.07 of the Revised Code.

(4) A halfway house as defined in section 2929.01 of the Revised Code.

(5) A state correctional institution as defined in division (A) of section 2967.01 of the ~~Revised~~ Revised Code or a prison as defined in division (BB) of section 2929.01 of the R.C.

CMS 2279-P
Graduate Medical Education (GME)

This proposed rule clarifies that costs and payments associated with GME programs are not expenditures for medical assistance that are federally reimbursable under the Medicaid program. CMS allowed states to include hospital GME activities either as a component of hospital services or separately. CMS is clarifying that GME is not a health service and therefore should be precluded from FFP. Prospective hospital payments currently can be supplemented by direct medical education (DME) or indirect medical education (IME) payments.

A 50 state survey report: Medicaid Direct and Indirect Graduate Medical Education Payment, indicates that while states view these Medicaid GME payments as critical to state GME policy, they generally do not track these payments. CMS is questioning the accountability of the states for GME expenses for which federal dollars are claimed. It is difficult to quantify Medicaid GME payments and monitor and measure the effect of Medicaid payments on GME programs. CMS is making it clear that GME is outside the scope of medical assistance, and that GME funding is not an allowable component of payment methodologies included in a state's approved Medicaid state Plan or in any Medicaid managed care payment.

The rule would also provide that when calculating an inpatient UPL, state's may not include additional payments Medicare makes to a hospital for direct educational costs as part of the reasonable estimate of Medicare payment. States may, as part of their UPL calculation, include Medicare payments for indirect medical education as these payments represent additional costs associated with providing services in teaching hospitals.

Currently in Ohio GME is included in the prospective payment for hospitals. Since Managed care rate setting follows FFS policies GME is also included in Managed care rates for the eligible population. The proposed rule will take the GME out of both payments i.e. FFS and Managed Care rates and therefore reduce the Medicaid budget significantly. According to BHPP, it will eliminate $33.4 million (FFS and MCO) in FFP for direct GME payments in SFY 2009 alone. This rule is estimated to reduce Federal Medicaid outlays by $140 million in FY 2008, by $290 million in FY 2009, by $440 million in FY2010, by $460 million in FY2012. It will be very expensive for states to continue to pay for GME through state only dollars.

— there are federal estimates

CMS 2213-P
Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper payment Limit

This proposed rule amends the regulatory definition of outpatient hospital services for the Medicaid program. The current definition is broader than the definition in Medicare and can overlap with other covered benefit categories. By closely aligning the definitions for Medicaid and Medicare it will improve the applicable upper payment limits (UPL).

Ohio has an UPL policy for outpatient clinics and the proposed rule will not have any impact on the definition. In Ohio RHC, school based services are excluded from the UPL definition. However, we agree with the comments submitted by Covington and Burling on behalf of our state and other states which are more directly impacted. The regulation is misguided because it prohibits the use of all inclusive rates in which payment for professional services may be bundled into an outpatient rate. The proposed rule penalizes hospitals that seek to serve people in their community by excluding services in outpatient clinics that are not departments of the hospitals.

Congressional Inquiry Response
January 30, 2008

CMS 2275-P **Health Care-Related Taxes**

Summary: This proposed rule would revise the threshold under the indirect guarantee hold harmless arrangement test to reflect the provisions of the Tax Relief and Health Care Act of 2006, Public Law 109-432, by proving that, when determining whether there is an indirect guarantee under the 2-prong test for any part of a fiscal year on or after January 1, 2008 through September 30, 2011, the allowable amount that can be collected from a health care-related tax is reduced from 6 to 5.5 percent of net patient revenues received by the taxpayer. This proposed rule would also clarify the standard for determining the existence of a hold harmless arrangement under the positive correlation test, Medicaid payment test, and the guarantee test (with conforming changes to parallel provisions concerning hold harmless arrangements with respect to provider-related donations); codify descriptions for two classes of health care services permissible under Federal statute for purposes of taxes on health care providers; and, remove obsolete transition period regulatory language.

Comment:

The Centers for Medicare & Medicaid Services (CMS) has proposed some narrow changes in the text of the regulations. But, the unrestrained meaning attributed to these changes is of great concern. Congress has rejected proposals similar to the current one, on the ground that they exceeded CMS's authority. The interpretations give CMS the latitude to find a hold harmless in almost any type of provider tax arrangement.

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law 102-234 (the "Provider Tax Amendments") established specific ground rules so that States could know in advance and apply with assurance that if they met the standards their taxes would be secure against federal challenge. That goal was crucial, for nothing is more unsettling to state governmental operations than to build and implement a budget only to be confronted later with a challenge to the validity of a funding source and a threatened loss of anticipated revenue (in this case federal financial participation (FFP) from the Medicaid program). The law established a detailed framework requiring that provider taxes be broad-based and uniform, and that no hold harmless result from payments made to providers. Consistent with congressional intent later laws gave States clear and precise means of distinguishing allowable and unallowable taxes.

Since their enactment the Provider Tax Amendments, and the regulations that implement them, have accomplished their purpose and have worked as anticipated by Congress. There have been few disputes over the meaning and the application of the provider tax rules since their enactment. There have been few significant issues over the application of the hold harmless provisions, for States understand that the law permits the use of provider tax proceeds to enhance Medicaid reimbursement of the taxed class, but that they may not structure those payments so as to return to the taxpayers the full amount of the tax collected or an amount varying based on the full amount, including the portion attributable to non-Medicaid activities.

The Provider Tax Amendment sets forth three hold harmless standards: the "positive correlation," "Medicaid payment," and "guarantee" tests.

The positive correlation test focuses on whether a non-Medicaid payment serves to repay taxpayers "dollar (or part of a dollar)-for-dollar for their tax costs." The statutory term "positive correlation" connotes something more than a mere relationship or association. CMS's current proposed rulemaking has asserted that a positive correlation may be established by vague "linkages" between the tax and of a non-Medicaid benefit.

The "Medicaid payment" test involves a focused inquiry: whether all or a portion of a Medicaid payment to the taxpayer "varies based only upon the amount of the **total** tax paid." Under this test, no hold harmless occurs unless the Medicaid payment varies in relation to the total (Medicaid and non-Medicaid) tax amount. The chief purpose of the section is to ensure that States do not hold the provider harmless, through Medicaid payments, for the non-Medicaid portion of its tax liability.

The "guarantee" provision examines whether taxpayers are assured that they will not be responsible for taxed amounts. A "direct guarantee" involves an explicit assurance in law that the taxpayer will be held harmless, in whole or in part. If an explicit guarantee exists, that tax would be impermissible and the two-prong test would apply. Since not all hold harmless situations are explicit, the indirect guarantee applies where there is no explicit assurance.

An "indirect guarantee' exists if the tax fails both parts of a two-pronged test. The first prong establishes the "safe harbor" of a tax that produces proceeds that do not exceed six percent of the **total** revenues of the taxpayer subject to the tax. If the tax collections exceed this safe harbor, the tax is then subject to a second test: whether 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other state payments. The premise of this "safe harbor" provision is that a tax imposed at no more than a normal rate for business taxes would be presumptively valid, but if a higher rate were utilized and the revenue of the taxed class was substantially derived from Medicaid payments, then the tax would be deemed to contain an indirect guarantee of repayment constituting an impermissible hold harmless. In December 2006, Congress confirmed the validity of the indirect guarantee "safe harbor" test of the regulations by incorporating the provision into section 1903(w)

(4) (C) of the statute. This law also temporarily lowered the safe harbor from six percent to 5.5 percent.

CMS asserts that "tax and payment amounts are positively correlated when they have a positive relationship with each other even when that relationship is not evidenced through a strict correlation in a mathematical sense." CMS's proposed interpretation of "positive correlation," particularly the notion that any form of "linkage" may be found to equal a hold harmless, defies the common understanding of the term "positive correlation" and removes the only identifying feature of this hold harmless test: an assessment of whether the tax amount and the payment amount increase or decrease in tandem. The "linkage" required to support a positive correlation under CMS's proposed new interpretation appears to encompass any causal or temporal connection as government policies between the tax and the payment. CMS's interpretation of "positive correlation" interjects some degree of subjectivity into the test. CMS asserts that it may identify correlation based on factors having nothing to do with the comparison of tax and payment amounts.

CMS proposes to construe, the "Medicaid payment" test, as providing a hold harmless "when the payment is conditional on the tax payment." CMS notes that this "clarification" does not preclude States that use cost-based payment mechanisms from including provider tax costs as one of the costs considered in setting individualized rates. CMS has previously acknowledged that providers' expenses for the Medicaid portion of provider taxes are allowable Medicaid expenditures.

CMS proposed to replace the term "amount of the **total** tax payment" with "the tax amount" in the Medicaid payment test. Under the Medicaid payment test, all or a portion of a Medicaid payment to the taxpayer must vary based only on the amount of the **total** tax. The word "**total**" is critical. The portion of a provider's health care-related tax payment attributable to Medicaid services is an allowable cost, and Medicaid reimbursement may be furnished for it. A tax can be claimed as an allowable cost and included in the establishment of reimbursement rates. A Medicaid payment that varies based on the Medicaid portion of provider tax amounts is permissible; only a Medicaid payment varying based on **total** provider tax amounts (including non-Medicaid portion) constitutes a hold harmless.

CMS should also retract its unwarranted assertion that a hold harmless exists under the "Medicaid payment" standard if a Medicaid payment is contingent on a provider's paying its tax. In that event, CMS states, "the variation between a payment of zero and a positive payment would be based only on the payment of the tax amount." A hold harmless exists if all or any portion of the Medicaid payment to a taxpayer varies based only upon the amount of the total tax paid. This is another way of stating that the total tax amount and the Medicaid payment are positively correlated. The fact that a provider must pay its taxes in order to receive a Medicaid payment does not establish a correlation between the two amounts. Many States authorize collection of delinquent taxes from any payments otherwise due to a taxpayer, including Medicaid payments. Collection of unpaid provider taxes by withholding amounts due for serving Medicaid patients is not a form of hold harmless.

CMS should restore the adjective "**total**" to the tax amount identified in the "Medicaid payment" provision. It should also abandon its position that a supplemental payment based on the payment of provider taxes attributable to Medicaid services is improper.

CMS asserts that no "explicit promise or assurance of payment" is necessary to constitute a direct guarantee. CMS states that the only element necessary to constitute a direct guarantee is "the provision for payment by State statute, regulation or policy." CMS should retract its proposed interpretation of this test, which, like its statements about "positive correlation" and "Medicaid payment," exceeds the agency's statutory authority. The mere fact that a state statute provides by law for a payment, offset or waiver to a provider or a provider's patient, and that some person might have a "reasonable expectation" that the taxpayer would be held harmless as a result, cannot suffice to establish a direct guarantee. The link between the benefit and the provider tax is so attenuated that without more there would be no basis for a finding of a "direct guarantee."

CMS's expansive interpretations of the "positive correlation" and "direct guarantee" tests obscure the differences between these two distinct tests, and would enable the agency to find either of the two tests met wherever a non-Medicaid benefit might conceivably be used to defray provider tax costs. Further, under CMS's broad interpretation of the "Medicaid payment" provision, CMS can find a violation in virtually any situation in which provider tax revenues are used to make Medicaid payments to taxed providers. The effect of these proposed interpretations is effectively to omit the "indirect guarantee" test.

A mere linkage between a grant or tax relief program for private-pay patients and a provider tax, absent specific evidence of a positive correlation or direct guarantee, is insufficient to establish a hold harmless. The phrase "amount of total tax payment" is essential to the rationale behind the hold harmless standard. The vague, subjective standards being proposed will give CMS a roving power to find a hold harmless violation on the basis of undefined "linkages" between tax and payment programs.

Comments regarding proposed modification to 42 CFR 433.56

In conformance with Section 6051 of the Deficit Reduction Act of 2005 (DRA), enacted on February 8, 2006, the proposed regulation establishes a provider tax class defined as "Services of managed care organizations (including health maintenance organization, preferred provider organizations)." CMS is encouraged to consider proposing a definition of the term "preferred provider organizations" so that states may know what entities must be included in a tax program on this class of providers for it to comply with the broad based requirements of the SSA and associated regulations.

Ohio – Franchise Fee impact

The basic provider tax issue revolves around CMS's insistence that the franchise permit fee (FPF) be reported as an allowable cost (like any other allowable costs) on the Medicaid cost report subject to a ceiling or price. CMS has cited Sec.433.68 (f)(3) of the CFR that states in part "...the tax will be considered held harmless...if the tax provides for any payment that guarantees to hold taxpayers harmless for ALL or a PORTION of the tax". This was the argument our CMS representative used when he also cited the proposed federal regulations as supporting the interpretation that an "add-on" appears to guarantee payment thus holding providers harmless. CMS also cited a 1995 State Medicaid Director Letter which permits the Medicaid portion of the cost of the Franchise Permit Fee to be included as allowable costs for purposes of Medicaid reimbursement. **Ohio has never had a hold-harmless provision associated with it's franchise fee programs.**

CMS has approved the ICF/MR FPF as an add-on in the state plan since FY 1994 yet challenged the add-on reimbursement methodology contained in the NF FY2007 state plan amendment TN06-010. After intervention by legal representatives, who argued against the premature implementation of the proposed regulations with CMS, TN06-010 was approved. Even with TN06-010 approved, future amendments could be jeopardized due to the looming implementation of the new federal regulations and the continued interpretation of CMS's 1995 State Medicaid Director Letter.

The following reflects the estimated FY 2008 fiscal impacts should CMS disallow the FPF add-on for NFs and ICFs-MR.

NF	$117,533,762.50	($6.25 x 18,805,402.0 claim days)
ICF-MR	$ 20,354,902.11	($9.63 x 2,113,697.0 claim days)
Total	$137,888,664.61	

$137.9 X 60% = $82.6 mill

Ted Strickland
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Helen E. Jones-Kelley
Director

30 East Broad Street Columbus, Ohio 43215-3414
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October 12, 2007

Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2261-P
P.O. Box 8018
Baltimore, MD 21244-8018

RE: CMS-2261-P: Comments on Proposed Rule Medicaid Program; Coverage for Rehabilitative Services

Ohio is grateful for the opportunity to comment on the Health and Human Services, Centers for Medicare and Medicaid Services (CMS) proposed rule to amend 42 CFR parts 440 and 441 to address coverage for rehabilitative services. The Ohio Department of Job and Family Services, Ohio's State Medicaid Agency, coordinated the below set of comments through collaboration with the Ohio Departments of Health, Education, Mental Health, Alcohol and Drug Addiction Services, Aging and Mental Retardation and Developmental Disabilities.

We appreciate CMS efforts to better define regulatory requirements regarding the provision of rehabilitative services, to improve integrity in the claim process for expenditures for the services, and to enhance consumer protection along the continuum of care. We agree that changes to the language are necessary to gain clarity, and to close loopholes that might currently exist in the rules. However, we are concerned about statements made regarding other areas of the CFR, and the limitations those statements create that may inhibit states from exercising some latitude to implement a healthcare program for their consumers that is effective, efficient, and compliant.

PROVISIONS OF THE PROPOSED REGULATIONS:

ISSUE:
Throughout the document there appears to be an ideology that the rehabilitation benefit does not cover services that are a part of other federal, state and local programs. Specifically, CMS proposes "in paragraph 441.45(b)(1) that coverage of rehabilitative services would not include services that are furnished through a non-medical program as either a benefit or administrative activity, including programs other than Medicaid, such as foster care, child welfare, education, child care, vocational and prevocational training, housing, parole and probation, juvenile justice, or public guardianship."

> **Comment:** We are particularly concerned with the exemption of education programs, as this appears to contradict statute. Specifically, the language at section 1903(c) of the

Social Security Act states, "Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of such Act." Paragraph 441.45(b)(iv) of the proposed rule, in addressing the education services not covered under the rehabilitation benefit, lists only "Routine supervision and non-medical support services provided by teacher aides in school settings..."

Recommendation: Since the prohibition appears to be limited to a very narrow and specific segment of the education system, we are requesting CMS to strike the reference to education from the list that indicates the things "rehabilitation does not include", and, if necessary, to make reference to only routine supervision and non-medical support services provided by teacher aides in school settings as opposed to referencing the education system as a whole.

ISSUE:
CMS "also proposes in paragraph 441.45(b)(1) that coverage of rehabilitative services would not include services that are intrinsic elements of programs other than Medicaid. It should be noted however, that enrollment in these non-medical programs does not affect eligibility for Title XIX services."

Comment: The specific instances considered "intrinsic elements" of programs other than Medicaid is unclear. A key area of concern is in the area of case management. While there are case management functions that occur in the foster care or child welfare system, there may be a need for case management, delivered through the mental health system as a component of community psychiatric support treatment, that is directly related to the mental health needs of the child. Additionally, the definition of "program" is not clear.

Recommendation: Provide clarification regarding the definition of "intrinsic elements" and "program", and give clear examples of the intent of this section.

ISSUE:
Under the proposed regulation, "...if specific provider qualifications are set forth elsewhere in subpart A of part 440, those provider qualifications take precedence when those services are provided under the rehabilitation option.", and reference is made to section 440.110 of the CFR. Specifically, the requirements for therapists providing services under the rehabilitative benefit should be consistent with the requirements in section 440.110. Paragraph 440.130(d)(1) contains the definition "Recommended by a physician or other licensed practitioner of the healing arts". However, section 440.110 references "prescribed" instead of the term "recommended".

Comment: In as much as prescription authority for the other licensed practitioners may vary from state to state, we support the use of the term recommended.

Recommendation: Include a definition for "prescribe" that includes the term "recommended" by licensed practitioners of the healing arts.

ISSUE:
In Sec. 440.130(d)(1)(iii), CMS proposes to "define 'Qualified providers of rehabilitative services' to require that individuals providing rehabilitative services meet the provider qualification requirements applicable to the same service when it is furnished under other benefit categories. Further, the provider qualifications must be set forth in the Medicaid State plan. These qualifications may include education, work experience, training, credentialing, supervision and licensing that are applied uniformly. Provider qualifications must be reasonable given the nature of the service provided and the population being served." CMS "will require uniform application of these qualifications to ensure the individual free choice of qualified providers, consistent with section 1902(a)(23) of the Act."

Comment: While we applaud the effort to improve the quality of services and to ensure comparability and the individual's free choice of qualified providers, there may be an impact to services through community mental health centers as well as case management through alcohol and drug (AoD) treatment centers, as they use "trained others" to deliver services reimbursed under the rehab option. Currently, under OAC 3793:2-1-08 (M)(3), case management through AoD treatment centers may be provided by "any staff member approved by the program director", and according to OAC rule 5122-24-01, "trained other" means an individual with training adequate to perform specific mental health services and who is not otherwise designated as a provider or supervisor, and who is not required to perform duties covered under the scope of practice according to Ohio professional licensure. "Trained others" may include peer supporter/support workers. There are no statewide qualifications defined for "trained others" specifically related to education, work, experience, training, etc. In addition, there are not specific qualifications listed for this type of service provider in the Medicaid state plan. By not allowing the use of "trained others" in the service delivery system or applying burdensome qualifications, there will be an increase in cost to the community mental health centers. Access will also be impacted given "trained others" render many of the lower-level services provided by community mental health centers.

Recommendation: Thoroughly consider the impact of the provider qualification requirements, especially for mental health and substance abuse programs.

ISSUE:
In section 441.45(b)(2), CMS proposes to exclude FFP for expenditures for habilitation services including those provided to individuals with mental retardation or "related conditions" as defined in the State Medicaid Manual section 4398. Physical impairments and mental health and/or substance related disorders are not considered "related conditions" and are therefore medical conditions for which rehabilitation services may be appropriately provided.

Comment: The term "related conditions" is ambiguous.

Recommendation: Provide clarification regarding which conditions are considered "related conditions".

ISSUE:
The proposed regulation references the practitioner of the healing arts who is licensed in the state to diagnose and treat individuals..." CMS has indicated in its proposed rule package that this area could also include therapists.

Comment: The use of the term "diagnose" may create compliance issues for some states. In Ohio, although psychologists, counselors, and social workers diagnose and treat, the therapists do not; the therapists evaluate and treat.

Recommendation: Change the term diagnose to "diagnose or evaluate."

ISSUE:
The proposed regulation specifies the need for a rehabilitation plan.

Comment: CMS expectations with regard to existing plans are unclear.

Recommendation: Provide clarification regarding whether CMS expects a separate plan be developed that is rehabilitative regardless of the existence of a service plan developed through an existing process. In the alternative, explain that the states have latitude to determine the sufficiency of such existing plans and processes, and to expand them, as necessary, to meet the requirements of this regulation.

ISSUE:
The proposed regulation specifies the need for a rehabilitation plan.

Comment: The distinction between restorative services and maintenance as they relate specifically to behavioral health services is unclear.

Recommendation: Provide clarification regarding the distinction between the concepts of restorative services and maintenance as they relate specifically to behavioral health services, and as it relates to children and older adults.

ISSUE:
Proposed regulation 440.130 is titled, "Diagnostic, screening, preventive, and rehabilitative services." Yet, the 1905(a)(13) of the Social Security Act (SSA) references "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services..."

Comment: The term "other" seems to imply services that do not fall into specific areas of the 1905(a) services.

Recommendation: Provide clarification on whether this section of the state plan could house the physical therapy, occupational therapy, speech-language pathology and audio

logy, and other services recognized in state law and provided by licensed practitioners licensed in accordance with state law.

ISSUE:
CMS indicates specific educational program accrediting bodies (actually a part of 440.110, which is indirectly referenced in this proposed regulation).

Comment: Ohio may use different accrediting bodies in the licensing of professionals.

Recommendation: Accept all nationally recognized accrediting bodies in addition to the ones indicated. Or, clarify the criteria used in choosing the proposed accrediting bodies.

Again, we appreciate the opportunity to comment. We remain committed to state and federal partnership on healthcare issues and encourages you to preserve State flexibility in Medicaid coverage and administration.

Sincerely,

/s/

Cristal A. Thomas
State Medicaid Director

CMS 2287-P

CMS 2287-P Elimination of Reimbursement for School Administration and Costs Related to transportation of School-Age Children Between Home and School.

The rule proposes no Medicaid payments for admin services performed by school employees & transportation to/from home for school-age children. Under the proposed rule, CMS would continue to reimburse states for the cost of school-based direct medical services under IDEA that are covered in their approved state plan. CMS is trying to avoid improper billing by school districts for administrative expenditures.

This may mean that more medical services will be provided by schools as direct care and school based providers may pursue payment from the MCPs for services that were previously billed administratively through BCA.

Transportation changes are insignificant, as non-emergency transportation was always allowed only to a medically necessary covered service. We believe this is not a significant change to current policy.

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Helen E. Jones-Kelley
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30 East Broad Street Columbus, Ohio 43215-3414
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February 1, 2008

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2237-IFC
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-2237-IFC: Comments on Interim Final Rule, Medicaid Program: Optional State Plan Case Management Services

Centers for Medicare and Medicaid Services (CMS):

Ohio requests that the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) consider Ohio's comments regarding the interim final rule which implements case management service provisions authorized by sections 1905(a)(19) and 1915(g) of the Social Security Act, in accordance with section 6052 of the Deficit Reduction Act of 2005. The interim final rule adds new provisions which amend 42 CFR parts 431, 440 and 441. The Ohio Department of Job and Family Services, Ohio's State Medicaid Agency, developed the following comments in conjunction with the Ohio Departments of Aging, Mental Health, Alcohol and Drug Addiction Services and Mental Retardation and Developmental Disabilities.

Ohio appreciates CMS efforts to better define regulatory requirements regarding the provision of case management services and to improve integrity in the claim process for expenditures for such services. While the rule's definition of case management services is mostly taken from the authorizing statute, the rule also expands upon the statutory language. Ohio has concerns about several provisions included in the regulation that expand upon the statutory language, the limitations and the impact such provisions may have on several current programs, and our ability to meet consumer needs in the most efficient and effective manner. For these reasons, Ohio asks that CMS consider the comments set forth below.

Background:
The interim final rule is not specifically clear that the policy clarifications apply to services outside of sections 1905(a)(19) and 1915(g) of the Act or to other non-state plan services. However, Ohio staff has received verbal guidance from CMS that the regulations shall apply to all forms of case management including "administrative case management" and case management services provided through a 1915(c) waiver. Ohio questions CMS' authority to extend the provisions for state plan services as contained in the Deficit Reduction Act to other forms of case management, including case management services provided through a 1915(c) waiver or under an administrative reimbursement mechanism. We request that CMS reconsider this expanded interpretation.

To the extent CMS holds to the position that the regulations do apply to forms of case management outside the scope of sections 1905(a)(19) and 1915(g) of the Act, Ohio requests that CMS clarify the authority they base this application upon. For those services provided through an approved 1915 (c) waiver using the administrative case management option, clearly define such activities and delineate which activities must be provided by the single state Medicaid agency and which activities may be delegated to other state agencies or contracted entities.

Provisions of the Interim Final Rule:

Ohio is concerned about the requirement that case management services be provided by a single Medicaid case management provider. Many individuals in Ohio's Medicaid system have a single case management provider. However, Ohio's system also supports the use of an inter-disciplinary approach, when consumers' needs cross delivery systems. Requiring that a consumer have only one Medicaid funded case manager collapses this system and may result in an individual receiving case management services from a case manager who does not have expertise in serving certain populations or needs. Case managers will need to expand their expertise and their time to singularly manage all service delivery systems and providers. This will result in the need for smaller case loads to accommodate an increase in case management intensity which will lead to increased program operation costs. For example, case managers for Ohio's aging or home care waivers would either need to become experts on the mental retardation and developmental disabilities (MRDD) system and have access to that system with the same authority as the MRDD system case managers or the MRDD system case managers would have to coordinate services for individuals enrolled in aging or home care waivers for those individuals who qualify for MRDD services.

The interim final rule requires that case managers not serve as gatekeepers to other Medicaid services. The provision prohibiting case managers from serving as gatekeepers will limit their ability to effectively coordinate services and manage program costs, especially as part of a 1915(c) waiver program.

Ohio also has concerns about the "any willing provider provision" to the extent that this provision applies to 1915(c) waiver programs that provide administrative case management services. Four of Ohio's 1915(c) waivers deliver case management under the administrative case management option to enable Ohio to assure that the expertise of case management providers matches the needs of the consumers targeted by each waiver. This provision will increase program costs, decrease efficiencies and require a major overhaul of Ohio's long term services and supports delivery system.

In addition, Ohio has concerns about the potential impact that limiting administrative functions such as level of care determinations, service plan approval and prior authorization of waiver services to only Medicaid state agency staff will have on access, efficiency and cost.

The interim final regulations allow individuals to elect to decline case management services. Ohio does not understand how this provision comports with 1915(c) waivers requirements. Waiver consumers are required to have a plan of care which is comprehensive and clearly delineates all their needed services. Creating such a plan is defined as a case management function. If an individual can elect to decline case management services, Ohio requests clarification on how a state can meet the requirement that the case manager develop a comprehensive plan of care. If the case manager has no role in developing, coordinating and monitoring a comprehensive plan of care, Ohio cannot maintain responsibility for program costs and assure a consumer's health and safety. This is a prime example of why Ohio contends that these regulations are not applicable to case management services provided outside the scope of 1905(a)(19) and 1915(g) of the Act.

Community Transition Activities:
Ohio is also concerned about the change in coverage for community transition activities. Currently, Ohio's MRDD targeted case management service covers such services during the last one hundred eighty days (180) of an individual's stay in an institution. Ohio believes this practice is consistent with policies issued by CMS in response to the Olmstead court decision. Ohio's experience is that in some cases even 180 days is not enough time to put into place all the necessary community supports to effectively transition an individual from an institutional setting to a community setting. The new regulations will significantly limit Ohio's ability to effectively assist individuals wishing to return to the community. This change will also impact Ohio's larger scale efforts to balance our long term care services and support system. The CMS concern regarding duplicative payment for transition services is not relevant in Ohio. The time and effort it takes to transition an individual from an institutional setting to a community setting far exceeds the scope of work undertaken by institutional discharge planners.

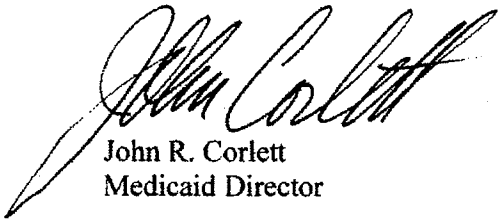
Given that most individuals agree that home and community-based services (HCBS) are oftentimes considered more appropriate for consumers and less costly to Medicaid programs, regulations should not impose restrictions that impede the process to transition individuals to HCBS settings. Moreover, the requirement that federal financial participation (FFP) will not be available until the consumer leaves the institution and is receiving medically necessary services coordinated by a community case management provider coupled with the requirement that a consumer can elect to decline case management services creates a disincentive for community-based case management providers to deinstitutionalize individuals.

Regulatory impact analysis:
Ohio believes that the estimated savings CMS projects with the implementation of these regulations is incorrect. The analysis incorrectly assumes that the only entity impacted by the proposed regulations is the state. In addition, the cost analysis fails to take into consideration a variety of factors. For example, Ohio projects an increase in CMS expenditures of more than $5 million per fiscal year from increased FFP resulting from a shift in funding case management services at the administrative rate to the federal medical assistance percentages (FMAP) rate.

Notwithstanding the change in funding case management services from an administrative to FMAP match rate, Ohio believes that the regulation will result in additional costs as well due to increased staffing needs, increased payments for case management activities, decreased controls, the need to restructure eligibility/service authorization and other gate keeping systems and significant changes to information technology systems to accommodate the newly required fifteen minute billing unit. For example, for Ohio's waiver for the elderly, such changes may result in additional costs of over $6.1 million (all funds) to address the regulatory provisions.

We appreciate the opportunity to comment. It is our understanding that CMS does not currently anticipate amending the interim final regulations based upon comments received through the public comment period. Ohio values the state-federal partnership by which we and CMS manage Ohio's Medicaid program and would appreciate CMS' consideration of Ohio's comments. Thank you.

Sincerely,



John R. Corlett
Medicaid Director

Impact of the Targeted Case Management Rule on Ohio's Waiver Programs
(TCM IFR) (CMS-2337-IFC)
Draft 01/28/07

The Deficit Reduction Act (DRA) of 2005 contained a section to clarify the Medicaid definition of case management when covered as a Medicaid state plan service. This clarification was intended to curb improper billing of non-Medicaid services to the Medicaid program. CMS has issued an Interim Final Rule (IFR), effective on March 3, 2008, to implement this section of the DRA.

Ohio is concerned that CMS is using this IFR as a vehicle to eliminate administrative case management as an option for the 1915(c) Home and Community-Based Services (HCBS) waiver programs through which states provide less-expensive community care as an alternative to more expensive institutional care. Waiver case managers are key to assuring waiver consumer health and safety and cost-effective community service delivery. The elimination of administrative case management goes beyond the Congressional intent of the DRA and will have a devastating impact on several of Ohio's 1915c HCBS waivers.

Though the proposed rules do not specifically address HCBS waivers, CMS has gone on record stating their intention that states will no longer be permitted to choose to provide case management as an administrative activity under an HCBS waiver. Historically, administrative case management combined what the IFR now defines as case management, such as designing and coordinating service plans, with certain Medicaid administrative activities, sometimes referred to as gate keeping activities. Gate keeping includes such activities as pre-admission review, prior authorization and eligibility determination. Ohio questions CMS' authority to extend the provisions for state plan services as contained in the Deficit Reduction Act to other forms of case management, including case management services provided through a 1915(c) waiver or under an administrative reimbursement mechanism.

CMS is differentiating case management from administrative activities, and indicating that any willing, qualified provider may furnish case management, whereas only the state Medicaid agency can perform administrative activities. The provision prohibiting case managers from serving as gatekeepers will limit their ability to effectively coordinate services and manage program costs, especially as part of an HCBS waiver program. Limiting administrative functions such as level of care determinations, service plan approval and prior authorization of waiver services to only Medicaid state agency staff will have a major impact on access, efficiency and cost.

An advantage of administrative case management is the state's ability to limit providers to entities that have expertise in serving an HCBS waiver's target population. For instance, in Ohio's PASSPORT HCBS Waiver that serves more than 27,000 elderly consumers, a network of 13 PASSPORT Administrative Agencies (PAAs) located in the state's 12 Area Agencies on Aging as well as one not for profit agency operate the program regionally and provide administrative case management to PASSPORT waiver consumers. Ohio has been using administrative case management in the PASSPORT waiver for 24 years with approval from CMS. The PAAs currently employ approximately 550 licensed social workers and registered nurses to perform the case management function. The PAAs will be forced to lay off their current case managers if CMS eliminates the option of administrative case management.

The IFR requires that a consumer have only one Medicaid case manager, and most individuals in Ohio's Medicaid HCBS system have only one. However, Ohio's system also supports the use of an inter-disciplinary approach, when consumers' needs cross delivery systems. Requiring that a consumer have only one Medicaid funded case manager may result in an individual receiving case

management services from a case manager inexperienced in serving certain populations or needs. Case managers will need to expand their expertise and devote extra time to manage across all service delivery systems and providers. This will result in the need for smaller case loads to accommodate an increase in case management intensity which will lead to increased program operation costs.

The IFR allows individuals to decline case management services in contradiction to CMS HCBS waiver program requirements. HCBS waiver provisions require each participant to receive services furnished under a comprehensive plan of care that clearly delineates the consumers' needs. Creating such a plan is defined as a case management function under an HCBS waiver. If the case manager has no role in developing, coordinating and monitoring a comprehensive plan of care, Ohio cannot responsibility manage waiver program costs nor assure participating consumers' health and safety.

Historically, Ohio has prohibited direct care service providers from also providing case management to avert the possibility of conflict of interest. The IFR as allows direct service providers to also furnish case management, inviting the possibility of self-dealing.

Ohio also is concerned about the new 60 day limitation introduced in the IFR on coverage of community transition coordination, a state plan case management service component, which consists of all the tasks involved in helping an institutionalized individual relocate to the community. Currently, Ohio's MR/DD targeted case management service, which is provided as a state plan service and not as an HCBS waiver service, covers community transition during the last one hundred eighty days (180) of an individual's stay in an institution. This amount of coverage is consistent with CMS policies issued in response to the Olmstead court decision. In some cases 180 days is not enough time to put into place all the necessary community supports to effectively transition an individual from an institution to a community setting. Moreover, the IFR requirement that FFP is not available until the consumer leaves the institution and is receiving medically necessary services coordinated by a community case management provider coupled with the IFR requirement that a consumer can decline case management services creates a disincentive for community-based case management providers to deinstitutionalize individuals.

CMS projects that the IFR will produce Medicaid cost savings. With potentially many new agencies and individuals providing case management and with the loss of key oversight for Medicaid waiver spending, it is simply not possible to achieve the savings CMS assumes in its impact statement. This is even more evident by the fact that if administrative case management is eliminated in favor of targeted case management, states like Ohio will be able to bill case management at the higher FMAP rate. Ohio projects an increase in CMS expenditures of $5 Million from this change alone. Ohio believes that the changes will result in an additional increase in costs due to increased staffing needs, decreased controls, and significant changes to information technology systems to accommodate a fifteen minute billing unit, newly introduced in the IFR. For example, for Ohio's waiver for the elderly, such changes may result in increased costs of over $6.1 million (all funds) to accommodate the regulatory provisions.

CMS indicates that the only the only entity impacted by the proposed regulations is the state. In Ohio, these regulations, especially if applied to 1915(c) waivers, impact local entities currently responsible for case management activities whether the activity is currently conducted as an administrative function or as a service.